



## Memorandum

Date FEB 4 1993

From Bryan B. Mitchell *Bryan B. Mitchell*  
Principal Deputy Inspector General

Subject Review of Medicare Credit Balances at Selected Hospitals in California (A-09-92-00050)

To William Toby, Jr.  
Acting Administrator  
Health Care Financing Administration

This is to alert you to the issuance on February 5, 1993 of our final report. A copy is attached.

The report discloses that Medicare accounts receivable credit balances included overpayments totaling an estimated \$18.8 million in California. The estimated overpayments are associated with 113 hospitals for whom Blue Cross of California (Blue Cross) served as the fiscal intermediary. The overpayments existed because both the hospitals and Blue Cross did not review credit balances and process adjustments timely. We are recommending recovery of the overpayments and procedural improvements to ensure that the hospitals and the intermediary perform more timely reviews.

The Office of Inspector General conducted a nationwide review of credit balances at 64 hospitals and 8 intermediaries. This intermediary report is one of the eight intermediary reports that will be used to estimate the national magnitude of Medicare credit balance overpayments. The objective of our hospital reviews was to determine if hospitals were reviewing Medicare credit balances to identify Medicare overpayments and making timely refunds to the intermediary. The objective of our review at Blue Cross was to evaluate its hospital credit balance monitoring and its processing procedures.

We randomly selected 8 of the 113 hospitals with 200 or more beds serviced by Blue Cross. Our review of credit balances at these hospitals showed that they received \$1,000,074 in Medicare overpayments which should have been refunded to the intermediary. Projecting the results of our review to the 113 hospitals, we estimated that the larger hospitals serviced by Blue Cross received and retained about \$18.8 million in Medicare overpayments.

Most of these overpayments occurred because the hospitals did not have adequate controls to accurately identify the primary

Page 2 - William Toby, Jr.

insurer, preclude billing the same services twice, and ensure that the services billed were actually performed. Other overpayments occurred as a result of system problems with the intermediary's new claims processing system. The hospitals did attempt to adjust many of the overpayments. However, the intermediary had not processed the adjustment claims in a timely manner.

We are recommending that Blue Cross recover all outstanding Medicare credit balance overpayments, process adjustment claims more timely, increase its audit coverage of credit balances, and require hospitals to establish procedures to periodically review Medicare credit balance accounts and refund all overpayments.

We issued separate reports to each of the eight hospitals. We also provided a draft of this roll-up report to Blue Cross for review and comment. Blue Cross agreed with the findings and recommendations in our report.

For further information, contact:  
Herbert Witt  
Regional Inspector General  
for Audit Services, Region IX  
FTS: (415) 556-5766

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE CREDIT  
BALANCES AT SELECTED HOSPITALS IN  
CALIFORNIA**



FEBRUARY 1993    A-09-92-00050



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX  
Office of Audit  
50 United Nations Plaza  
San Francisco, CA 94102

CIN A-09-92-00050

Mr. Leonard Schaeffer, President  
Blue Cross of California  
P.O. Box 70000  
Van Nuys, California 91470

Dear Mr. Schaeffer:

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services report titled, "REVIEW OF MEDICARE CREDIT BALANCES AT SELECTED HOSPITALS IN CALIFORNIA." Your attention is invited to the audit finding and recommendations contained in the report. The official named below will be communicating with you in the near future regarding implementation of these items.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS/OIG Office of Audit reports are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the above common identification number in all correspondence relating to this report.

Sincerely,

Herbert Witt  
Regional Inspector General  
for Audit Services

Enclosures

HHS Contact:

Michael Piazza  
Associate Regional Administrator  
Division of Medicare  
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San Francisco, California 94105



Region IX  
Office of Audit  
50 United Nations Plaza  
San Francisco, CA 94102

CIN: A-09-92-00050

Mr. Leonard Schaeffer, President  
Blue Cross of California  
P.O. Box 70000  
Van Nuys, California 91470

Dear Mr. Schaeffer:

This report provides you with the results of our REVIEW OF MEDICARE CREDIT BALANCES AT SELECTED HOSPITALS IN CALIFORNIA. A Medicare credit balance occurs when reimbursements for services provided to a Medicare beneficiary exceed the charges billed. The objective of our review was to determine if hospitals were reviewing Medicare credit balances and refunding identified Medicare overpayments to Blue Cross of California (Blue Cross).

We randomly selected eight hospitals for review: Little Company of Mary Hospital, Mission Hospital, Northridge Hospital, Peralta Hospital, St. John's Hospital and Medical Center, Tri-City Medical Center, University of California San Diego Medical Center, and University of California San Francisco Medical Center. Blue Cross was the designated fiscal intermediary for these hospitals.

Our review at the eight hospitals identified \$1,000,074 in Medicare overpayments that had remained outstanding for more than 60 days. Using accepted statistical methods, we estimate that about \$18.8 million in Medicare overpayments had been received and retained by the larger hospitals under Blue Cross' jurisdiction.

We identified seven primary causes for the Medicare overpayments. We found that most of the overpayments occurred because the same services were reimbursed by Medicare and another insurer, payments were made in excess of billed amounts, duplicate claims were submitted for the same services, and payments were made in excess of dialysis rates. Other overpayments occurred because payments were made on Health Maintenance Organization claims when no payment was due, billings were submitted for services not performed, and payments were received for charges which were subsequently reversed by the hospital.

In separate reports to the hospitals reviewed, we are recommending that they establish procedures to periodically review all Medicare credit balances and refund all identified Medicare overpayments to the intermediary within 60 days. The hospitals generally concurred with our recommendations and agreed to take corrective actions. However, they stated that the intermediary was largely responsible for the overpayments not being returned to the Medicare program within the prescribed time frame.

Our review at Blue Cross showed that the intermediary was slow in processing adjustments and that it was not significantly emphasizing a review of credit balances in its audits. We are recommending that Blue Cross: (i) recover all outstanding Medicare credit balance overpayments, which we estimate to be about \$18.8 million, (ii) process adjustment claims on a more timely basis, (iii) increase audit coverage to include a review of hospitals' procedures over Medicare credit balances and the timely refunding of overpayments, and (iv) require hospitals to establish procedures to periodically review Medicare credit balance accounts and refund all overpayments. Blue Cross agreed with our finding and recommendations.

## BACKGROUND

Title XVIII of the Social Security Act established the Medicare program to provide health care services to the aged and disabled. The program covers inpatient services under Part A and outpatient services under Part B. The Health Care Financing Administration (HCFA) is the Federal agency responsible for administering Medicare. The HCFA contracted with the Blue Cross and Blue Shield Association to act as the fiscal intermediary for providers in several states, including California. The Blue Cross and Blue Shield Association subcontracted with Blue Cross of California to act as the fiscal intermediary for California. As the fiscal intermediary, Blue Cross was responsible for processing and paying claims for services provided to Medicare beneficiaries.

Credit balances for Medicare beneficiaries occur when reimbursements for a beneficiary exceed the charges billed. Credit balances can result from duplicate payments made by an intermediary, or from payments made by an intermediary and other insurers for the same service provided to the same patient. In these cases, a Medicare overpayment exists and should be refunded to the intermediary. Credit balances may also result from errors in calculating the contractual allowances, errors in calculating the coinsurance, and other accounting errors. In these cases, a Medicare overpayment is unlikely to exist.

The HCFA is now requiring intermediaries to begin using shared claims processing systems. In November 1990, Blue Cross of California implemented a shared claims processing system called the Florida Shared System (FSS). The FSS system was developed by an intermediary in Florida and is scheduled to be used by approximately

six intermediaries. The new system eliminates the need for using hard copy adjustment billings by allowing providers to electronically enter adjustments directly into the Blue Cross computer.

Although Blue Cross officials indicated that the new FSS system is an improvement, several problems have been encountered which have affected the identification and adjustment of the overpayments identified in our review. These problems, which will be discussed in detail in the "Results of Audit" section of this report, were partly responsible for the overpayments not having been refunded to Medicare in a timely manner.

### SCOPE OF AUDIT

Our audit was made in accordance with generally accepted Government auditing standards. The objective of our audit was to determine if hospitals were reviewing Medicare credit balances to identify Medicare overpayments and making timely refunds to the intermediary.

Our review was part of a nationwide review of Medicare credit balances. Eight intermediaries were randomly selected nationwide and eight hospitals were randomly selected at each intermediary. Blue Cross of California was the intermediary selected for California. Our review was limited to hospitals with over 200 beds. In California, there were 113 such hospitals for whom Blue Cross served as the fiscal intermediary.

At each hospital, we separately analyzed outpatient and inpatient credit balances for Medicare beneficiaries to determine if Medicare overpayments had occurred. We did this through use of such records as credit balance runs, patient files, remittance advices, hospital payment histories and intermediary payment histories.

Our review was limited to credit balances that had been outstanding at least 60 days. At each hospital, we randomly selected 100 Medicare outpatient credit balances between \$101 and \$10,000. If there were less than 100 accounts on the hospital's accounting records, we reviewed all of the recorded accounts. We reviewed all inpatient credit balances over \$1,000 and all outpatient credit balances over \$10,000. We projected the results of our review to the universe of 113 hospitals using statistical sampling techniques.

Our review was limited to Medicare credit balances established by the hospitals. We did not review the hospitals' policies and procedures for establishing credit balances, for identifying primary insurers, or for processing Medicare claims to the intermediary. The amounts due Medicare were discussed with both hospital and intermediary officials in order to (i) validate our conclusions, (ii) identify the reasons for the overpayments, and (iii) determine if refunds had been made to the intermediary.

We followed up our hospital reviews with a review at the intermediary. We traced a judgmental sample of adjustment claims to Blue Cross' claim processing system to determine the length of time the intermediary took to process the overpayments. We also reviewed Blue Cross's provider audit program for review of Medicare credit balances.

Our field work was performed at the eight hospitals and at Blue Cross' office in Los Angeles from April 1991 through October 1991.

### RESULTS OF AUDIT

The eight hospitals we reviewed had received and retained \$1,000,074 in Medicare overpayments over 60 days that should have been refunded to the intermediary. Projecting our results, we estimate that the larger hospitals serviced by Blue Cross had received and retained about \$18.8 million in Medicare overpayments that should have been refunded to the program. We are 90 percent confident that the retained overpayments were between \$9,795,749 and \$27,836,459.

In addition, our review at Blue Cross disclosed that it was slow in processing adjustment claims and that its audit did not ensure that overpayments were properly identified and refunded by the hospitals.

### HOSPITAL REVIEWS

Our review of eight Medicare participating hospitals serviced by Blue Cross showed that all eight hospitals had Medicare credit balances recorded on their accounting records at the time of our review.

We reviewed a total of 920 Medicare credit balances at the eight hospitals: 691 outpatient credit balances between \$101 and \$10,000, 6 outpatient credit balances over \$10,000 and 223 inpatient credit balances over \$1,000. We found that 383 of the 920 credit balances, or 42 percent, represented Medicare overpayments totaling \$1,000,074 (\$418,347 for outpatient services and \$581,727 for inpatient services).

Projecting the results of our review to the 113 hospitals in the universe, we estimate that the hospitals have received and retained about \$18.8 million in Medicare overpayments. The \$18.8 million represents the point estimate of the combined projections, consisting of \$7,227,803 for outpatient credit balances between \$101 and \$10,000, \$3,372,942 for outpatient credit balances greater than \$10,000, and \$8,216,906 for inpatient credit balances.



As shown below, many of the 383 credit balances remained on the hospitals' accounting records for long periods of time:

|            | <u>Number of<br/>Credit Balances</u> | <u>Days on Hospitals' Accounting Records</u> |                |                |                |
|------------|--------------------------------------|--|----------------|----------------|----------------|
|            |                                      | <u>61-200</u>                                | <u>201-400</u> | <u>401-600</u> | <u>&gt;600</u> |
| Outpatient | 287                                  | 94   | 80             | 32             | 81             |
| Inpatient  | <u>96</u>                            | <u>55</u>                                    | <u>19</u>      | 9              | <u>13</u>      |
| Total      | <u>383</u>                           | <u>149</u>                                   | <u>99</u>      | <u>41</u>      | <u>94</u>      |

The number of days shown in the chart was computed from the date that the overpayment was entered into the accounting system to the date of the credit balance list provided to us by the hospital.

These overpayments existed on the hospitals' accounting records for an average of 431 days. According to hospital officials, these credit balances existed for such a long period because (i) the new FSS claims system implemented by the intermediary in 1990 was unable to process adjustment bills during the period November 1990 through May 1991, (ii) the intermediary had not been responsive in processing their overpayment requests, (iii) the intermediary had advised the hospital personnel not to make any adjustments until the FSS system is capable of processing them, and (iv) the hospital did not have sufficient staff to routinely review all credit balances.

Our review identified seven primary causes for the Medicare overpayments. They were: services reimbursed by another insurer, payment in excess of billed amounts, duplicate payments, payment in excess of dialysis rates, payment for Health Maintenance Organization claims when no payment was due, billings for services not performed, and payment for charges which were subsequently reversed.

Most of these overpayments occurred because the hospitals did not have adequate controls to accurately identify the primary insurer, preclude billing the same services twice, and ensure that the services billed were actually performed. Other overpayments occurred as a result of system problems with the intermediary's claims processing system. The hospitals did attempt to adjust many of the overpayments. However, when requested, no action had been taken by the intermediary prior to our review.

The table below summarizes the reasons for the overpayments in our review.

| <u>Reason for<br/>Overpayment</u>         | <u>Number of<br/>Overpayments</u> | <u>Outpatient<br/>between<br/>\$101 &amp; \$10,000</u> | <u>Outpatient<br/>over<br/>\$10,000</u> | <u>Inpatient</u>   | <u>Total</u>        |
|---|-----------------------------------|--|---|--------------------|---------------------|
| Services reimbursed<br>by another insurer | 141                               | \$1,763,597  | \$ 82,636                               | \$5,052,032        | \$6,898,265         |
| Payment in excess<br>of billed amount     | 1                                 |  | 3,040,406                               |                    | 3,040,406           |
| Duplicate billings                        | 173                               | 3,254,711  |   | 3,006,624          | 6,261,335           |
| Payment in excess<br>of dialysis rate     | 28                                | 1,395,604  | 249,900                                 |                    | 1,645,504           |
| HMO claims                                | 5                                 | 65,502   |   | 158,250            | 223,752             |
| Services not performed                    | 24                                | 413,173  |   |                    | 413,173             |
| Charge reversals                          | 9                                 | 311,986  |   |                    | 311,986             |
| Other                                     | <u>2</u>                          | <u>23,230</u>  | <u>          </u>                       | <u>          </u>  | <u>23,230</u>       |
| Total                                     | <u>383</u>                        | <u>\$7,227,803</u>                                     | <u>\$3,372,942</u>                      | <u>\$8,216,906</u> | <u>\$18,817,651</u> |

The estimates in this table were calculated using a multistage sampling design for each reason for overpayment.

#### Services Reimbursed by Another Insurer.

We estimate that Medicare overpayments totaling \$6,898,265 resulted from hospitals billing Medicare and a commercial insurer for the same services and receiving primary payments from both. The provisions of the Medicare Secondary Payor (MSP) Program state that Medicare's reimbursement will be limited if primary coverage is available from another insurer. Further, the Medicare Intermediary Manual, paragraph 3491.1, indicates that, when another insurance is determined to be the primary payer, Medicare should not be billed until payment is received from the primary payer.

Payments in Excess of Billed Amount

We estimate that Medicare overpayments totaling \$3,040,406 resulted from the intermediary making payments in excess of the charges billed. According to Blue Cross officials, the FSS system would, from November 1990 through May 1991, sporadically make very large overpayments on provider claims. The cause of the system problem was not specifically identified; however, Blue Cross officials stated it was corrected with the implementation of a system update in October 1991.

Duplicate Billing of Services

We estimate that Medicare overpayments totaling \$6,261,335 resulted from hospitals submitting duplicate claims for the same services. The duplicate payments were undetected because (i) duplicate claims were submitted as revised billings, (ii) duplicate claims were submitted using different service dates, (iii) the same services were erroneously billed for two different beneficiaries, (iv) identical claims were submitted and paid by the intermediary, (v) the same services were billed under different provider numbers, (vi) the same services were billed as both inpatient and outpatient, and (vii) duplicate claims were submitted using different revenue codes.

The intermediary did not identify many of these claims as duplicates because the second claims were not identical to the original claims. According to Blue Cross officials, the new claim processing system will be able to identify these claims as duplicates. As for the identical claims, they could not explain why they were paid.

Payments in Excess of Dialysis Rate

We estimate that Medicare overpayments totaling \$1,645,504 resulted from the intermediary paying in excess of the composite rate for the dialysis services. Medicare regulations require that dialysis services be paid at the composite rate. When the dialysis segment of the FSS system was implemented in February 1991 through April 1991, many of the dialysis charges billed to the intermediary were paid based on the provider's billed charges rather than the composite rate. According to Blue Cross officials, a system update was implemented in October 1991 to correct these overpayments.

Health Maintenance Organization (HMO) Claims

We estimate that Medicare overpayments totaling \$223,752 resulted from the intermediary making payments on HMO claims when no payment was due. The HMO claims were submitted to the intermediary for the purpose of updating the patient's

history file. These claims were processed because either the intermediary's claims processing system was not able to read the patient's history file correctly or the history file itself was incorrect. Medicare overpayments were being made on HMO claims under the intermediary's old and new claims processing system through June 1991.

#### Services not Performed

We estimate that Medicare overpayments totaling \$413,173 resulted from hospitals billing for services not performed. Usually this occurred when hospitals anticipated that a service would be performed. Subsequent to submitting the claims to the intermediary, the hospitals became aware that the services were not performed and cancelled the charges. The hospitals established credit balances for the Medicare payments received.

#### Charge Reversals

We estimate that Medicare overpayments totaling \$311,986 resulted from hospitals billing the intermediary for services in which the charges were subsequently reversed by the hospital. In these cases, the services were indeed performed. However, the hospitals chose to cancel the charges after the billings had been submitted to the intermediary for payment.

#### INTERMEDIARY REVIEW

All eight hospitals expressed concerns that Blue Cross was a contributing factor to the problem of unresolved credit balances and outstanding overpayments. Therefore, we followed up our hospital reviews with a limited review at Blue Cross. We reviewed Blue Cross' processing of adjustment claims and provider audit coverage of hospital credit balances. We found that Blue Cross' practices did contribute to the existence of Medicare overpayments at the hospitals.

#### Processing of Adjustment Claims

The hospitals informed us that they had submitted adjustments to Blue Cross for many of the overpayments we identified, but had not received notice from Blue Cross indicating that the overpayments had been adjusted. The hospitals believed they were not responsible for the length of time these overpayments were on their records. To determine if Blue Cross was a contributing factor to the problem of outstanding Medicare overpayments, we traced a judgmental sample of 17 adjustment claims to Blue Cross' records.

We found all 17 claims pending in the FSS. The 17 adjustment claims took an average

of 107 days to enter the system, beginning from the date the hospital made its first request to the date it was accepted by the FSS. According to Blue Cross officials, a mass adjustment will be performed in the near future to correct these overpayments.

The FSS had many system problems during the first year of its implementation. These problems were partly responsible for the overpayments not being processed timely. From November 1990 through May 1991, the FSS could neither process adjustments submitted on-line nor in hard copy billings. Furthermore, Blue Cross officials informed us that they received no funds from HCFA for processing adjustments or cancellations. Therefore, Blue Cross had assigned a low priority for processing adjustment claims.

#### Provider Audit of Cost Reports

Our review disclosed opportunities for Blue Cross to improve its monitoring of hospital credit balances. Blue Cross reviews hospital Medicare credit balance accounts in its audits of hospital cost reports. These audits require Blue Cross to determine if the provider is taking proper action to identify cases where Medicare is a secondary payer (MSP).

Although Blue Cross requires that the hospital provide a current listing of Medicare credit balances for inspection, the intermediary does not evaluate the completeness of the listing nor the hospital procedures for Medicare credit balances. The credit balance listing is forwarded to Blue Cross' MSP department for investigation and adjustment. After receiving the credit balance listing, the MSP department has nine months to investigate and adjust the credit balance accounts. Our review indicated that the MSP department does not adjust all credit balances within the nine month period. Blue Cross auditors are not required to follow up on the status of these credit balances.

### CONCLUSIONS AND RECOMMENDATIONS

Based on our reviews at the hospitals and at the intermediary, we concluded that procedural improvements are needed at the hospitals and at Blue Cross if Medicare overpayments are to be identified and refunded timely. We recommend that Blue Cross:

1. Recover all outstanding Medicare credit balance overpayments, which we estimate to be about \$18.8 million.
2. Process adjustment claims on a more timely basis.

3. Increase audit coverage to include a review of hospital procedures over Medicare credit balances and the timely refunding of overpayments.
4. Require hospitals to establish procedures to periodically review Medicare credit balance accounts and refund all overpayments.

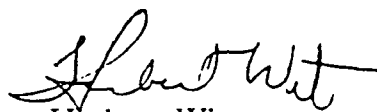
Auditee's Comments

In a written response dated August 28, 1992, Blue Cross agreed with the finding and recommendations in our report. Blue Cross' comments to our draft report are included in their entirety as Appendix A.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS/OIG Office of Audit Services reports are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification please refer to the above common identification number in all correspondence relating to this report.

Sincerely,



Herbert Witt  
Regional Inspector General  
for Audit Services

Enclosures

HHS Contact:

Michael Piazza  
Associate Regional Administrator  
Division of Medicare  
Health Care Financing Administration  
75 Hawthorne Street, 4th Floor  
San Francisco, California 94105

## APPENDIX

Medicare  
Program

Blue Cross  
of California



APPENDIX A

August 28, 1992

Federal Medicare  
Intermediary

P.O. Box 70000  
Van Nuys, California 91470  
(818) 703-2345

Mr. Herbert Witt  
Regional Inspector General  
Office of Inspector General  
Office of Audit  
50 United Nations Plaza  
San Francisco, CA 94102

Re: Blue Cross of California-Medicare Credit Balances

Dear Mr. Witt:

This letter is to acknowledge receipt of your recommendations and findings for Medicare Credit Balances.

We appreciate and concur with your findings in regards to the problem areas identified by the auditors. Several of the problems identified were in the early stages of our corrective action plans.

Situations such as mistaken Medicare Secondary Payer payments, End Stage Renal Disease payments paid incorrectly, or HMO claims that should have received no payments have already been corrected through mass adjustments.

Although hospitals that are holding duplicate payments due to Medicare being the secondary payer need to submit adjustments, they may do so through the credit balance project, by submitting a check, or by the submission of an adjustment via Direct Data Entry or a hardcopy claim.

Blue Cross of California-Medicare is committed to providing the best service possible to all our providers and beneficiaries. We appreciate your recommendations and efforts in assisting us in accomplishing our goals.

If you have any questions, I can be reached at (818) 593-8502.

Sincerely,

Juliette Chenian  
Manager  
Medicare Claims Administration

JC:bh